

Drug Treatment, Managed Care and the Courts

From Conflict to Collaboration

Written by

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From Conflict to Collaboration

Introduction

There are now more than 1,500 drug courts in operation or being planned in the United States¹, and many states are actively expanding the availability of treatment for offenders. The Conference of Chief Justices, the Conference of State Court Administrators and the American Bar Association have endorsed drug courts' principles and methods.² The federal government is supporting their further development with \$38.5 million in 2004, and another \$67 million proposed by the White House for 2005.

If drug courts are to realize their full potential, however – if they are to improve public safety, reduce costs and lower rates of recidivism among drug-abusing offenders – they will have to address a number of on-going challenges. Those challenges include working with the “dually diagnosed” defendant; expanding the range and availability of treatment options; researching the most effective forms of treatment; and securing ongoing funding to sustain court operations over the long haul.

This paper focuses on a particularly difficult challenge for drug courts: health insurance and, in particular, managed care organizations. What do drug courts have to do with managed care? Managed care plays a key role in the delivery of all forms of medical care – including substance abuse treatment. By the year 2003, an estimated 184.7 million Americans were enrolled in some form of managed care – a dramatic increase from the early 1980s when few people had heard of it.³

Of particular concern for drug-court practitioners is the fact that Medicaid – the government-sponsored health insurance that covers a significant percentage of drug-court clients – is fully engaged in moving participants into managed-care plans.⁴ Of the nation's 33.7 million Medicaid beneficiaries, 56 percent were enrolled in managed care by 2000, a significant jump from 1995 when only 9.8 million Medicaid subscribers were enrolled.⁵ And most states, believing that managed care policies can save money while expanding access to services, have plans to continue moving their Medicaid population into managed care in the years to come.

Interestingly, managed care and drug courts have some things in common. Both managed care and drug courts began as experiments to address problems in their respective fields. Managed care's primary goal over the last two decades has been to cap rising health care costs. Drug courts' principal aim has been to halt the criminal justice system's “revolving door,” ensuring that drug-addicted offenders don't return to court again and again. Both drug courts and managed care organizations have enjoyed demonstrable success: Widespread reliance on managed care signifi-

cantly slowed the growth of health care costs in the 1990s;⁶ drug courts have reduced recidivism and drug use among participants.⁷

While both innovations have achieved significant results, they have not, by and large, enjoyed the smoothest relations with one another. Drug courts and managed care organizations often have very different views about the needs of their substance-abusing clients. For drug courts, the problem of substance abuse is social, economic, behavioral, and, perhaps most importantly, criminal. Because their view of substance abuse is so broad, their concept of “treatment” is equally broad: it includes not only achieving abstinence from drugs, but job training, family counseling, links to housing and more. Only in this way do drug courts feel they can facilitate an offender’s successful re-integration into the community as a law-abiding citizen.

For managed care organizations, on the other hand, addiction is purely a medical condition. In this light, “treatment” is more narrowly defined, consisting of the medical steps necessary to get a patient off drugs. While a drug court considers services such as job training or parenting-skills classes as crucial components of treatment, these services are outside a managed care organization’s purview. In essence, managed care organizations and drug courts are characterized by two different models of care: the former by a “medical model of care,” the latter by a “‘psycho-social-behavioral’ model of care.”⁸

This creates the potential for a disconnect: A drug court may order a client into a particular course of treatment, but the client’s managed care organization may refuse to pay for it. In this way, managed care can have a significant impact on where and how substance abusers receive treatment. Where are the crucial points of intersection between managed care entities and drug courts? There are several:

Immediacy Time is of the essence in a drug court, which uses the crisis of an arrest to link offenders to treatment services immediately. Managed care can work against this effort, however, since it often takes days or weeks for a managed care organization to review and approve a request for treatment.

Access to Treatment Drug courts want access to a broad range of treatment modalities. Guided by recommendations from clinical staff, they also want the power to decide where and for how long clients are in treatment. Managed care organizations, however, limit treatment in a number of ways: in the types of treatment covered, the length of treatment, and by requiring clients to see only those providers in their network.

Accountability Drug courts, through close judicial monitoring, hold offenders accountable for their actions. But when managed care organizations also have a role in treatment decisions, many courts have found that clients can exploit cracks in the system. According to Daniel Forget, of the New York Office of Alcohol and Substance Abuse Services: “You have the judge saying one thing, the managed care organization saying another thing, someone in the welfare office saying something

else. For drug abusers, who are very skilled at manipulating situations, this is too good to be true.”⁹

Drug courts also seek to hold treatment providers accountable. But managed care organizations can potentially hamper drug courts in this area, too. The problem arises when treatment providers feel torn by the need to please both the drug court and the managed care provider. Most treatment providers rely, at least in part, on referrals from managed care organizations. So some treatment providers may fear that by recommending treatment plans managed care organizations think are excessive, or by regularly appealing denials of coverage, they risk being dropped from the network.¹⁰ These concerns can place treatment providers in an awkward situation, and, ultimately, make it more difficult for drug courts to hold them accountable for the quality and type of care they provide.

Despite their profoundly different approaches to substance-abuse treatment, there is reason to believe that drug courts and managed care organizations can work more collaboratively. To achieve this collaboration, both players need to understand each other better. For drug court practitioners, this means understanding how managed care works, how it has the potential to affect court operations and how to respond effectively to the challenges it poses. For managed care organizations, it means understanding drug court principles and goals, the growing body of research that supports the drug court approach and the particular needs of criminally involved clients.

This white paper is intended to guide drug court practitioners toward building a more collaborative relationship with managed care organizations. The first two sections of the paper provide background on the history of managed care, its philosophy, its effect on substance-abuse treatment and its impact on drug-court operations. The paper then explains how some drug courts have built successful relationships with managed care organizations. It concludes with a list of nine strategies to facilitate collaboration. These strategies emphasize the importance of strengthening communication between drug courts and managed care organizations and also urge drug court advocates to play an active role in shaping their state’s health care policy.

Development of Managed Care

Managed care as it is practiced today in the United States can be traced back to the 1920s and 1930s when several communities around the country began experimenting with a form of health insurance known as prepaid cooperative practices. The most well-known of these experiments began in the Mojave Desert in the 1930s when Dr. Sidney Garfield sought to make medical care available to thousands of men building the Los Angeles Aqueduct. In order to pay for a 12-bed hospital, Garfield collected a fixed amount of money per covered worker – basically, five cents daily for each participant. Through this method – now commonly referred to as “prepayment” – Garfield was able to hire staff and support his hospital’s work.

In Garfield’s day, perhaps the most important feature of pre-paid medicine was that it sought to bring medical care to remote regions or under-served populations.

By collecting prepayments – rather than fees after a service had been performed – Garfield ensured a steady stream of income that was not dependent on keeping a steady stream of sick patients flowing through his doors.

Over the years, several other prepaid plans emerged around the country, including the Group Health Association in Washington D.C. in 1937, and the Health Insurance Plan (HIP) of Greater New York, launched in 1947.¹¹ But because organized medicine, especially the American Medical Association, was staunchly opposed to prepaid medicine – largely because it limited both the earning power and discretion of doctors – these plans remained a minor player in the field of health insurance for the next several decades. Rather, the field was dominated by the “fee-for-service” model. Under that model participants were not limited to a select group of doctors or health-care providers, but could visit anyone. Also, in contrast to pre-paid plans, fee-for-service plans did not provide incentives to keep costs down; providers were reimbursed for every service they provided, and thus the more work they did, the more money they made.

**Health
Maintenance
Organizations**

The next significant chapter in the development of managed care plans was written during the Nixon administration. In an attempt to address a number of issues, including cost containment and access to medical care – especially for the poor, minority groups and the uninsured – the Nixon administration started in 1971 to promote the development of what it called “health maintenance organizations” (HMOs).¹² The administration offered grants and loan-guarantees to support the creation of HMOs, and the Nixon-sponsored HMO Act of 1973 preempted state laws that banned prepaid groups, requiring companies with at least 25 workers to offer an HMO option to their employees.¹³

The growth of the industry was relatively slow, however, despite the White House’s enthusiasm. It wasn’t until health care costs began to skyrocket in the late 1970s and early 1980s – when insurance premiums paid by private employers were rising an average of 15 to 20 percent a year¹⁴ – that HMOs began to look more appealing to employers and employees alike.

**Answering the
Crisis**

Gradually, the types of managed care organizations multiplied. Where originally there had been only the staff model HMO (pioneered by Garfield in the desert), today there are numerous variations on the theme, including “group model HMOs,” “network model HMOs,” and independent practice associations.¹⁵ All rely on pre-payments and a limited panel of “participating” providers to control costs. In addition, there are so-called managed care hybrids, which combine principles of fee-for-service insurance and HMOs. The most common of these hybrids are “preferred provider organizations” (PPOs). PPOs don’t use pre-payment, but instead reimburse participating providers according to a discounted fee schedule.¹⁶

In contrast to the traditional fee-for-service insurance model, all of the managed care models impose extensive rules on when and how members access care. For instance, in addition to requiring members (as patients are called) to visit only “par-

ticipating” providers, many managed care organizations also require members to obtain prior approval before seeing specialists. This practice permits the managed care organization both to control costs and ensure that a medical professional – often the member’s family doctor or “primary-care physician” – is coordinating each member’s care. The pre-approval protocol has proven so popular that even many traditional health plans have begun to employ it.¹⁷

In their effort to control costs, managed care organizations have also been responsible for the proliferation of so-called “one-stop shops,” which make it easier for patients to access a range of specialized treatment. And they emphasize preventive medicine by providing, for example, free routine check-ups. In this way, they invest resources up front to prevent illness rather than pay for more costly treatment after a member gets sick. In addition, managed care organizations have been credited with enhancing access to care by making it financially feasible for medical providers to work in traditionally under-served communities.

Medicaid Managed Care

By the mid-1980s, states were confronting sky-rocketing Medicaid costs,¹⁸ and also a decline in the number of providers willing to accept Medicaid’s low rates of reimbursement. This led states to turn to managed care. By June 1997, every state but Alaska and Wyoming had implemented some form of Medicaid managed care.¹⁹ By the year 2000, 56 percent of Medicaid participants nationwide were enrolled in a managed care plan.²⁰

From a financial perspective, the effects have been remarkable. From 1990 to 1992, Medicaid spending increased at an annual rate of 27.1 percent. But from 1992 to 1995, the growth rate dropped to 9.7 percent, and by 1996 had fallen to 2.3 percent, the lowest rate of growth in the history of the program.²¹ Although a number of factors contributed to the slower growth in Medicaid expenses, the move to managed care deserves at least some of the credit.²²

Since many, if not most, drug court clients are Medicaid recipients, drug court practitioners need to understand how Medicaid managed care is being implemented in their jurisdictions. This task, however, can be a challenge since each state sets its own financial eligibility criteria, benefit packages and payment policies. In 1994, individual states covered between 40 to 60 percent of their low-income population; that same year, total per capita Medicaid expenditures varied from a high of more than \$4,800 per low-income person in the highest-spending state to a low of just under \$1,000.²³

In addition, the conversion to managed care is not being handled in a uniform way. Some states and counties are limiting Medicaid managed care to narrowly defined populations, such as individuals with multiple mental illnesses or children with disabilities. Others are working with all Medicaid beneficiaries. And some jurisdictions allow health plans to assume full financial risk for all the services they provide, while others ‘carve out’ specific services – such as behavioral health or drug treatment – to be provided in the public sector or through separate health care contracts.²⁴

Managed Care and Substance Abuse Treatment

Regardless of the form managed care takes in a particular state, there's no question that it has had an impact on the delivery of all forms of medical care, including substance-abuse treatment. Managed behavioral health, which includes both substance-abuse treatment and other mental health services, has grown into a \$4 billion industry, and of the approximately 250 million Americans with health insurance, about 158 million are involved in some form of managed mental health program.²⁵

This has had a profound effect on treatment providers and their clients. Some treatment providers and client advocates feel that the rise of managed care has corresponded to a drop in overall coverage for substance-abuse treatment. A study commissioned by the American Society of Addiction Medicine, for example, found that the value of addiction insurance coverage had declined by 75 percent between 1988 and 1998 for employees of mid- to large-size companies.²⁶

Managed care has also been linked to “a drastic reduction” in the length and frequency of inpatient hospitalization for substance abuse.²⁷ One study looked at how a state's Medicaid patients fared when treated in health maintenance organizations rather than through traditional fee-for-service plans. The study found that managed care programs identified fewer patients needing alcohol or drug treatment. In addition, the study found that managed care programs did not cover residential care. Perhaps unsurprisingly, treatment outcomes for HMO clients were worse than for those treated under fee-for-service plans.²⁸

A study by the New York State Office of Alcoholism and Substance Abuse Services found that lengths of stay were shorter and the number of treatment visits were fewer when the service was reimbursed by Medicaid managed care.²⁹ The report also found that treatment providers were dissatisfied with Medicaid managed care. Providers reported that they sometimes delivered less intensive levels or shorter durations of care than clinicians recommended because managed care organizations didn't approve additional treatment. They also said that the additional paperwork and phone calls required by managed care organizations forced them to spend more time on administrative issues and less on clinical issues.³⁰

Daniel Forget, director of system resources at the New York State Office of Alcoholism and Substance Abuse Services, confirms these impacts: “Managed care has dramatically affected our system for many clients, reducing length of treatment and forcing people into levels of care that might not be appropriate to their clinical need,” he says.

And yet some studies paint a more positive picture of managed care's effects on substance-abuse treatment. One study, published in the *Journal of the American Medical Association*, for example, found that in Oregon, Medicaid-eligible residents saw an increase in access to substance-abuse treatment programs after the Oregon Health Plan in 1995 adopted a managed-care chemical dependency benefit. Specifically, the percentage of Medicaid-eligible clients admitted to substance abuse treatment programs during a calendar year increased from 5.5 percent of enrolled members in 1994 to 7.7 percent in 1997.³²

Availability of Services

In addition to affecting individual treatment plans, managed care has had a macro-effect on the availability of treatment services. Some experienced treatment providers have been excluded from managed-care plans because they don't meet the plans' criteria for infrastructure, resources or services. As a result, some treatment providers, due to a loss of income, have been forced to close or leave the field; this has led to a reduction in the number of treatment slots available in certain communities.³³

Further, some Medicaid managed care plans may no longer cover clients who had previously qualified for treatment. In the past, Medicaid traditionally covered "acute mental health services, detoxification, and some substance abuse rehabilitation services that emphasize rehabilitation... Some states are now narrowing their scope of responsibility," writes Mady Chalk, of the federal Center for Substance Abuse Treatment. "As a result, clients enrolled in Medicaid managed care plans may not have severe enough problems to qualify for state block-grant-funded mental health or substance-abuse services but may exhaust their managed Medicaid benefits and 'fall through the cracks' for significant periods of time."³⁴

Managed care organizations are aware of these trends, but say that they represent a much-needed shakeout in a system that had grown bloated and inefficient. They argue that the lengthy stays in treatment under fee-for-service plans reflect a wasteful over-utilization of services. In essence, managed care companies say they are applying a new rigor to the delivery of health care, and that their standards exist not to deny patients care but to ensure that they receive only that care which is "medically necessary." Managed care organizations also point out that many customers and providers are highly satisfied with the care they receive.³⁵

'Braiding'

Some states have tried to reduce the impact of managed care organizations on substance-abuse treatment by identifying alternative funding sources. Many providers rely on a mix of funds from insurance companies and other sources in a process sometimes referred to as "braiding." This approach, however, can pose logistical challenges, especially for treatment providers. One representative of a managed care provider describes the situation this way: "The provider is totally caught in the middle. There are some things they can charge the client for, some things they can charge the court for and some things they can charge the insurance company for. The treatment should seem seamless to the client, but to the management and billing departments, it's a lot of work."³⁶

In Delaware, which has seven drug courts, practitioners have overcome some of the financial limits imposed by managed care organizations by drawing on state funds set aside specifically to fund services ordered by a drug court that aren't covered by insurance. But the pot of money isn't limitless. "You have to be careful not to spend all the money," says Judge Richard S. Gebelein, chief of Delaware's Criminal Trial Division. "You have to decide on a case-by-case basis. In some instances the individual absolutely positively needs treatment and so we pay for it right away out of state funds. But there are other cases where the need is not quite as overwhelming,

so you try and stretch the funds as far as you can by working out a compromise with the HMO, if possible.”³⁷

In New York, advocates for the chemically-addicted tried to limit the reach of managed care organizations by lobbying to retain fee-for-service coverage for a number of treatment-related services. With the consolidation of alcohol and drug services into “chemical dependence” categories in April 2002, Medicaid managed care plays a role in delivering only a few key services, such as inpatient rehabilitation and detoxification services. Treatment on an out-patient basis, including methadone maintenance, is covered by Medicaid on a fee-for-service basis. Still other services, such as longer term residential care, are reimbursed under a different payment stream. In addition, New York’s has a “deficit funding system” that draws on money from the state Office of Alcoholism and Substance Abuse Services to meet the cost of services that are not reimbursed under Medicaid or other payment systems.³⁸ Judges in New York and elsewhere can also turn to public hospitals that offer treatment programs to handle clients without viable insurance coverage.

Impacts on Drug Courts

Despite these local efforts, managed care still has a significant effect on where and how substance abusers receive treatment – which means they can have a direct impact on drug court operations. Decisions by managed care organizations can affect how quickly participants access treatment, the range of treatment options and the ability of the court to hold defendants and treatment providers accountable.

Drug courts and managed care organizations often disagree about a range of issues – everything from the best treatment modality to a definition of what it means to be addicted and how one determines a treatment “success.” This is largely because drug courts take a broader approach to treatment, weighing not only medical factors, but social, economic and criminal justice ones as well. For drug court practitioners, it is not enough to see a client obtain physical sobriety. The goal of drug court, after all, is not just to get addicts sober but to help ensure that they do not return to court again as a defendant. In other words, helping offenders overcome the obstacles to a stable, law-abiding life is just as important to a drug court as achieving sobriety. Toward that end, a drug court considers services such as housing, child care, education, vocational rehabilitation, parenting skills classes, and counseling essential components of treatment. Drug courts feel – and numerous studies back them up – that recovering addicts who receive these supportive services are less likely to relapse or commit future crimes.³⁹

Of course, these “wraparound” services are not usually covered by a health care plan.⁴⁰ This is in large part due to the fact that health insurance plans look at drug addiction as an illness, and don’t consider the social, economic and public safety dimensions of the problem. The insurance plan’s concern is getting a client off drugs today; as such, insurers have historically paid little or no attention to factors like housing or job training that address the potential problems of tomorrow.⁴¹

Making things even more complicated is the issue of punishment. While the judge relies heavily on the recommendations of clinicians, who assess the treatment

needs of each client, the judge must consider the criminal justice issues as well. A drug court judge, for example, might order residential treatment not only because it's appropriate for a particular client's medical needs but because the severity of a client's offense or his past history of offending requires a high level of supervision. Alternatively, a judge might shorten a treatment plan because of the low-level nature of an offense; in this way, the judge tries to make sure the punishment is proportionate to the crime.

The drug court judge's measuring stick could be called "social necessity" – that is, not only what's medically appropriate for the client, but what's socially appropriate as well. The judge is seeking a mandate that makes sense in terms of the severity of the offense, the concerns of the prosecutor and defense attorney and social factors, such as a client's employment status, housing situation and family responsibilities. This places the judge in potential conflict with the managed care organization, which uses "medical necessity" as its guide. To a managed care organization, residential treatment doesn't make sense if the medical facts demonstrate that a client can achieve sobriety just as well at a less costly out-patient program. From managed care's perspective, the criminal justice issues are irrelevant. (It's also important to note that "medical necessity" itself can mean different things to different people. Within the medical community there are different views on the nature of addiction, the most effective treatment modalities and definitions of success.)⁴²

The conflict between "social necessity" and "medical necessity" can also lead managed care organizations to refuse to pay for services that drug courts use to hold clients accountable. The most obvious example of this is urine analysis. A managed care organization may only cover urine tests for a couple of months, while a drug court often requires that clients be regularly tested for the duration of treatment – a time span frequently measured in years, not months.⁴³

The health insurance industry in general has had, at times, good reason to mistrust the criminal justice system. Before the creation of drug courts, judges often mandated drug treatment after considering only the criminal justice issues and without properly assessing a defendant's clinical needs (in large part because they lacked staff and resources to conduct a proper assessment). They also lacked the capacity to monitor clients to see if they completed treatment as ordered. Some treatment providers worried that in certain cases judges were using residential treatment as a substitute for incarceration, regardless of whether residential treatment was medically appropriate. Even though drug courts have now professionalized the process, improving monitoring and actively avoiding residential treatment as a substitute for incarceration, some of the earlier mistrust still lingers.⁴⁴

Bridging the Gap

In an effort to bridge the gap between "medical" and "social" necessity, some states have adopted uniform standards for identifying substance abusers and the appropriate level of care. Delaware's contract with managed care organizations signed in July 2001 actually required managed care organizations to use assessment criteria established by the American Society on Addiction Medicine (ASAM). "The contractor can-

not unilaterally indicate that the court-ordered treatment does not meet medical necessity,” says Kay Holmes, chief administrator for Medicaid managed care in Delaware, describing the contract.⁴⁵

There is a larger question, however, that in Delaware and elsewhere remains unanswered: If residential treatment, urine analysis and supportive services like job-training and parenting-skills classes are important for the success of drug courts, who is going to pay for them? While drug courts would like to see some of these services included in a client’s overall health insurance package, managed care organizations – as well as other insurance providers – are clearly not prepared, or even financially capable, of paying for them. Rather than blame one side or the other, both sides need to realize that in many ways the debate about how to pay for comprehensive drug-treatment services is still unresolved. Society as a whole has yet to determine whether treatment systems for substance abuse and mental disorders should address public health and safety needs or focus exclusively on reducing or eliminating the medical manifestations of these conditions. If treatment systems – whether financed under managed care or not – “are to do more than reduce symptoms (as most consumers in the public sector have come to expect and most providers to attempt), then we need to develop funding and guidelines that reflect these broader goals,” writes Mady Chalk in *Quality Management in Health Care*.⁴⁶

Working Together

While the larger societal debate about how to treat substance abusers and who should pay for it continues, many drug courts and managed care organizations have found a way, at least on a local level, to resolve conflicts and meet the needs of both parties. Because Medicaid managed care plans – as well as drug courts – vary from jurisdiction to jurisdiction, it is difficult to describe these solutions in global terms. What follows, therefore, are detailed descriptions of two successful collaborations – in Buffalo, New York, and Philadelphia, Pennsylvania – and a discussion of the lessons they offer drug court practitioners elsewhere.

New York: Encouraging Cooperation

In New York, courts received an important tool from the Legislature, which, in the mid-1990s, adopted a bill requiring Medicaid managed care plans to pay for court-ordered treatment. The law covers all Medicaid managed care recipients, which, along with traditional fee-for-service Medicaid, make up the majority of New York’s drug court clients.

Because of the law, the court does not have to negotiate with plan managers over the details of treatment. The law even requires Medicaid managed care organizations to pay for treatment provided outside the managed care organization’s network. The court, in other words, can determine the type of treatment, the length of treatment and the provider of treatment – and the managed care organization is obliged to cooperate.

While the law is straightforward, its implementation hasn’t always been smooth. Some managed care organizations reportedly resisted the new rules at first, and that has fueled fears among some drug court practitioners and client advocates that the

law won't be around much longer. "This law could be here today and gone tomorrow," says Judge Robert Russell, who presides over the Buffalo Treatment Court. He says that because the law antagonizes managed care firms, there might eventually be an organized effort to have the statute reviewed and changed. Before that happens, Russell thinks it's important to build "a working relationship" with the local HMOs, one that's built on mutual cooperation and not the power of a legislative order.⁴⁷

The Buffalo Experience

In Buffalo, therefore, Russell takes a different approach: Instead of issuing official court orders, he has encouraged managed care organizations to cooperate voluntarily. "It just made good sense to reach out to those who are paying for treatment services to explain to them what drug court is, and try and get their buy-in," Russell says. Toward that end, Russell invited top officials from managed care organizations to his court. They observed courtroom proceedings and then met with the judge in his chambers. Russell explained to them how drug courts have significantly reduced recidivism among drug abusers.⁴⁸

"What Russell basically said was, 'Pay now for long-term treatment that works so you don't pay later when clients come back again and again for shorter treatment that's less successful,'" says Jack O'Connor, director of Medicaid managed care for the Erie County Department of Social Services, who attended the meeting with the judge and the HMO executives. "From that day on, word basically got out: Don't question things from the drug court, just pay the bills. Of course, they still argue with the court about length of stay, but now we have a protocol for working that out."⁴⁹

Greg Nuessle, senior manager of behavioral health at Univera Healthcare, a health maintenance organization serving the Buffalo area, says regular communication with the court has helped increase understanding on both sides. "There's a lot of collegiality. It's been a very good relationship," he says. The court, he says, has a thorough grasp of Univera's criteria, while Univera has come to see how the court can help patients succeed. "By holding patients accountable, the court increases attendance and compliance, and it also improves treatment outcomes," Nuessle says.⁵⁰

On-Site Representative

O'Connor himself is an example of how drug courts can "sell" themselves. In the mid-1990s, O'Connor participated in a panel where he learned about drug courts for the first time. "I didn't want to participate in the panel and I even got into a big argument with my boss about it. But I went, and I really was impressed. I saw what good work the drug courts were doing, and now I'm their biggest fan," O'Connor says.

O'Connor's enthusiasm led him to volunteer: on weekends, he runs the Buffalo court's alumni association, which offers support to successful graduates. But even more importantly, O'Connor's support has translated into meaningful policy. For one thing, he has smoothed communication between managed care organizations and the criminal justice system by assigning someone on his staff to work full-time in each of Erie County's six drug courts. Since O'Connor's office is responsible for administering the county's managed care contracts, the HMOs listen when his workers call. This saves time for drug court staff who no longer have to get on the phone

with an HMO every time a Medicaid managed care client walks through the door.

“In the beginning, the HMOs weren’t paying anything. The court would order detox, but wouldn’t call the HMOs to get permission,” O’Connor says. “It was a very easy ‘no’ for the HMOs because they didn’t know what was going on. Now, my worker in the court gets hold of the HMOs right away, and they’ll sit down and figure something out.” Having a representative from the Social Services Department in the courtroom doesn’t necessarily guarantee that the judge always gets what he wants, but the relationship has remained cordial and outright denials of coverage have been virtually non-existent. “There’s usually a give and take on both sides,” O’Connor says.

Having a representative from the county’s Department of Social Services in the courtroom has also helped eliminate other insurance-related problems. For instance, the Department of Social Services, as part of a statewide welfare reform effort, would remove clients from Medicaid for a number of reasons; and while this was consistent with the state’s welfare-reform policies, it interfered with the court’s ability to place these clients in treatment. “If they don’t show up for treatment, or miss just one session, we can close their case,” O’Connor says. “And once we close the case, nobody pays for treatment.” The Department of Social Services was also closing cases if a client went to jail – even if the jail term was a sanction of the drug court. “The judge might put someone in jail as a wake-up call, but then we’d close the case. So when he got out of jail, he no longer had insurance to pay for treatment,” O’Connor says.

To solve this problem, O’Connor assigned one worker in the county Medicaid office to handle only drug court cases. “The caseloads are the same, but instead of having 100 cases from all over, the worker has 100 cases from the Buffalo Drug Court, and he won’t close a case until he hears from my worker in the courtroom. That way, we don’t close a case until we understand what the judge wants... We try to hang with the case as long as the judge does,” O’Connor says. Medicaid cases must also be re-certified annually, and a client who fails to go through the re-certification process is dropped from the rolls. So the Social Service Department worker in each drug court flags cases that are due for re-certification and expedites the process to ensure that Medicaid remains in effect.

Recognizing that the law hasn’t always translated into harmonious communication between the court system and managed care organizations, the New York State Health Department has endorsed Buffalo’s approach. Although the Health Department acknowledges that courts are free to select providers as they see fit, the Health Department has encouraged judges to refer to in-network providers when practical; the Health Department has also asked the managed care organizations to add to their network programs that the courts favor.

**Philadelphia:
Creating a City-Run
HMO**

In one of the most ambitious responses to the challenges imposed on drug-treatment services by managed care, the City of Philadelphia created its own managed care organization, Community Behavioral Health. Community Behavioral Health has effectively addressed many of the concerns of treatment providers and drug court advocates and in the process developed something unique – the largest behavioral

health managed care organization in the country devoted to serving public sector clients, and the only one operated by a governmental body.⁵¹

The initiative – which was developed by Estelle Richman, then health commissioner and currently the state’s secretary of public welfare – was designed to address many of the criticisms sometimes leveled at managed care plans, including delays in treatment, excessive obstacles to obtaining care and too many outright denials of service. It also represented an improvement over a system that had grown unwieldy – what the *Philadelphia Inquirer* called “a crazy-quilt system in which Medicaid clients ... received mental-health care through HMOs, county programs and directly on a fee-for-service basis from private doctors and counselors.”⁵²

Supporters of Community Behavioral Health – who include city and state officials, as well as patient advocates – thought that the government could do a better job, in part because, unlike a private company, it wouldn’t look to make a profit. Although the local HMO industry was strongly opposed to the creation of Community Behavioral Health, tales of the industry’s excesses helped the initiative gain approval. For instance, city officials, in an attempt to convince City Council members to approve the plan, cited a 1992 analysis that found that one large health maintenance organization had received \$20 each month per welfare recipient to furnish mental-health care, and then turned around and paid a subcontractor only \$6.75 to deliver the actual services – allowing the HMO to pocket the difference.⁵³

A city-run agency would also take a broader view toward mental-health and substance-abuse treatment, one more consistent with the standards of “social necessity” than of “medical necessity,” supporters of the innovative plan argued. Rather than keep its focus entirely on the medical needs of its behavioral health clients, as was the case with privately run HMOs – the government-run initiative would provide a “seamless” stream of services for the poor. In other words, the agency would work closely with other city agencies to provide housing, education, counseling – whatever was needed to support a client recovering from drug addiction or other mental-health problems.

Living Up to Its Promise

So far, Community Behavioral Health, which was launched in February 1997 and received an Innovations in American Government Award from Harvard University and the Ford Foundation in 1999, has lived up to its promise. Rather than having Medicaid clients on numerous different for-profit plans, each with its own network of providers and each with a financial incentive to deliver the minimum level of care required by medical necessity, the city, which also has responsibility for the county offices of substance abuse and mental health, has placed all Medicaid clients on a single city-run plan.

By combining in a single behavioral health system these three entities – Community Behavioral Health, the Coordinating Office of Drug and Alcohol Abuse Programs, and the Office of Mental Health – Philadelphia can provide a comprehensive system of behavioral health services to Medicaid, uninsured and under-insured clients. “It’s an integrated behavioral health system where people receive the services

they need in a seamless way, despite moving from one funding stream to another,” according to Barry Savitz, assistant health commissioner, who oversees drug court treatment services for Philadelphia’s behavioral health system.⁵⁴ In its first year, Community Behavioral Health saved \$21 million – money that was channeled into city services, including improved care for the mentally ill homeless and behavioral health services at public schools.⁵⁵

The re-organization of the city’s behavioral health services has further produced a managed care organization that looks at overall outcomes rather than just the day-to-day bottom line, Savitz says. “We look at a global budget. If the person doesn’t do well in treatment they could end up committing a crime and be incarcerated. And there are associated costs with that as well, like having more kids in foster care. So by paying for treatment up front, and providing comprehensive services to support clients in recovery, the city is saving in the long run,” Savitz says.

Working with the Drug Court

Richman developed the proposal for Community Behavioral Health over the course of seven years – a process that began long before the Philadelphia Treatment Court opened its doors. Although the initiative was not created to respond to the needs of the city’s drug court, it has nonetheless proved to be an excellent partner in the court’s effort to get defendants into treatment.

For one thing, unlike a traditional private HMO, Community Behavioral Health is far more likely to pay for the kind of lengthy treatment the Philadelphia Treatment Court might be inclined to mandate. “Ninety-nine percent of the time there’s agreement between Community Behavioral Health and the court because we all have the same philosophy and the same bottom line – improving outcomes for patients,” Savitz says. “Community Behavioral Health has a different philosophy than most for-profit managed care plans. For one thing, it acknowledges social necessity. ... People who do need long-term residential treatment, get it.” About 10 percent of the treatment court’s clients are in residential treatment, Savitz says.

The Philadelphia Treatment Court actually works with two distinct funding streams, although both are government-run. Clients entering the court are usually uninsured, which means they have to submit an application to Community Behavioral Health for coverage. Until the approval comes through – and it can take up to 30 days – the client’s treatment is paid on a separate city budget line. “Having that temporary funding is a major key to providing treatment right away,” says Amy Hafner, clinical supervisor at the Philadelphia Treatment Court. “It allows us to get the client into a program, where the physician on staff can verify that the client is unemployable. That, in turn, makes it easier to get benefits under Community Behavioral Health.”⁵⁶

Hafner says the court works well with Community Behavioral Health. “They rarely challenge our assessments. They’ve learned through experience that our assessment unit is a credible one. If we make a recommendation, as long as it’s backed up clinically, they almost always approve it,” Hafner says. Hafner says that the government-run insurer has actually improved the court’s assessment capabilities

because often Community Behavioral Health knows about a past treatment episode that a client may have failed to report. “We rely on clients to self-report about their drug use, and they aren’t always forthcoming about past attempts at treatment. So sometimes Community Behavioral Health knows more than we do, and can tell us that this person dropped out twice before. That information can help us make a more appropriate treatment recommendation,” Hafner says.

Hafner says that initially the court used to contact Community Behavioral Health through a toll-free number, which meant they ended up speaking to a different person with every call. That system proved to be cumbersome and inefficient, so the court and the health plan came up with something else: “Now we have just one person there who handles all the clients coming from the treatment court. That helps tremendously because she understands how we work, and can give us the time we need to go over every case carefully,” Hafner says.

Hafner sees only one area in which she thinks the system could be improved. “I wish we could expedite the Community Behavioral Health application process,” Hafner says, noting that clients currently must visit their local welfare office to process the application. “Some don’t want to go into a welfare office because they view it as a stigma, even if they’re only applying for health coverage and not cash benefits. It’s actually part of the judge’s order that the client apply for health benefits, but still sometimes we have to take them ourselves to the welfare office. If we could just fill out the application ourselves, it would speed things up.”

Savitz says the basic principle underlying the approach to behavioral health care in Philadelphia is the belief that a city-run managed care organization is more accountable to the public than a private sub-contractor. “We want to treat the people who go through treatment court as a prudent investment in public safety. Before Community Behavioral Health, we had criminals coming in whom treatment providers assessed at one level of care but the private managed behavioral health care organization believed needed a lower level of care. But in the end, it’s not the private managed care organization’s dollars, it’s public dollars, which should be spent in a way that meets all of a client’s social service needs.”

Lessons from the Field

The issues confronting drug courts as they work with managed care organizations vary from state to state, and sometimes county to county. Everything is variable, including the laws and policies governing managed care, the methods employed by individual drug courts and the structure of each managed care organization.

Thus the successful experience of a single locality, such as Philadelphia or Buffalo, cannot always be readily translated to other jurisdictions. What can be translated, however, are some of the principles underlying their success. Perhaps the most important principle is the belief that both parties have important roles to play, and that in fulfilling their roles, they can, in fact, support each other.

Once drug courts and managed care organizations understand each other better, they will hopefully see that they have more to gain by collaboration than by conflict. Drug courts, for example, can help managed care organizations achieve their goal of

cost-containment by: improving success rates of treatment, and thereby reducing the likelihood that a client will return again and again for costly services; monitoring the performance of treatment providers, and encouraging the development of the most accountable and effective programs; and deploying their own staff to monitor a client's progress so that managed care organizations do not have to. Managed care organizations, on the other hand, can support the work of drug courts by: expanding networks of providers to reach under-served communities or populations, using the quality-assurance data they collect to help drug courts identify the treatment programs that are most effective, and expanding access to coverage by keeping down costs and making premiums more affordable.

Drug court planners, as well as treatment providers and client advocates – beyond improving a drug court's relationship with its managed care providers – also need to have a say in government policies affecting the delivery of health care, such as welfare reform and Medicaid managed care. And they need to develop persuasive arguments to explain to policymakers how the work of drug courts produces positive outcomes for society, including a reduction in criminal recidivism, an increase in long-term sobriety and a lessening of clients' dependence on other government services.

Clearly, each jurisdiction needs to develop its own strategy. But any successful approach would likely incorporate some of the following:

Learn How Managed Care Works in Your State In order to have a credible and effective voice in the shaping of health care policy, drug courts and substance abuse treatment providers need to understand how health care is delivered in the era of managed care. Which kinds of treatment are covered, and which are not? What criteria do managed care organizations use to determine who has a drug or alcohol problem? What are the rules governing Medicaid managed care? How do welfare reform efforts affect Medicaid managed care? How many drug court clients are uninsured? How many have managed-care coverage? How many are in fee-for-service plans? How much will the various insurance providers reimburse for different forms of treatment? Drug court planners also need to learn about alternative funding streams to cover clients without insurance, or clients whose plans deny or limit coverage.

Understand the Needs of Managed Care Drug courts and drug treatment providers need to understand that managed care organizations have their own goals and missions, ones that emerged from the national struggle with rising health-care costs. Managed care officials may be suspicious of the criminal justice system, which in the past may have mandated medical treatment without conducting proper assessments or providing suitable monitoring. Further, drug court supporters need to understand the market pressures that managed care companies face – they can't provide additional benefits (such as longer treatment) without raising their premiums.

Provide Managed Care Organizations with Information about Drug Courts Drug court practitioners can only help their cause by educating managed care executives

about how drug courts work and what they've learned so far about the most effective paths to recovery from addiction. Drug courts can give managed care officials a tour of the court and invite them to a face-to-face discussion with the judge – as Judge Russell did in Buffalo. One goal of this effort should be to demonstrate that, while courts in the past might have mandated substance-abuse treatment without conducting thorough assessments or follow-ups, drug courts are different. They have professionalized the process of court-mandated treatment and enhanced the monitoring process. Drug courts can also highlight research that demonstrates lower recidivism rates among program graduates; this will hopefully show that an investment in comprehensive treatment up front will save resources by reducing the need for second and third treatment episodes down the road. Once managed care organizations understand the needs and strengths of drug courts, and vice-versa, then they can begin to develop partnerships that provide mutual support.

Improve Communication Among the Court, Treatment Providers and Managed Care Organizations Beyond simply educating managed care organizations about the goals and methods of drug courts, drug courts and their various partners should find a way to make managed care organizations and other funders of treatment part of the “team.” Daniel Forget, of the New York Office of Alcohol and Substance Abuse Services, says there are a number of ways to enhance communication: First, build personal relationships, which means maintaining a friendly dialogue among court staff, treatment providers and decision-makers at managed care organizations. Second, drug courts and their partners should include representatives from managed care organizations at the outset of the planning process in order to give them a stake in the court. “The point to make,” Forget says, “is that this isn’t just the judge’s drug court, or the criminal justice system’s drug court, but it’s also the managed care organization’s drug court, too.” And third, drug courts and their treatment partners need to have professionals on staff who can talk the language of managed care. “When it’s time to get tough, the drug court really needs to know its stuff and ... have solid alcohol and drug-abuse professionals who can argue persuasively about the client’s treatment needs,” Forget says.⁵⁷

Collect Data Drug courts need to collect data to identify the most effective treatment options. Managed care organizations can assist in the collection and monitoring of this data. The uses of this data are many. It can, for example, demonstrate to managed care organizations and state Medicaid programs under what circumstances longer lengths of stay correlate to better long-term outcomes. It can also demonstrate whether or not – and under what circumstances – more expensive residential treatment can be more effective than out-patient care. Ultimately, data is crucial for drug courts, as they seek to hold offenders accountable, and for managed care organizations, as they seek to deploy treatment resources in a cost-effective and efficient manner.

Educate State Policymakers Drug court planners and treatment providers need to make sure that state policymakers appreciate the value of both drug treatment and drug courts. Persuading states to cover alcohol and drug treatment involves showing them “the cost offset savings for patients and society after effective ... treatment,” according to Susan L. Becker of the Center for Substance Abuse Treatment. “Former substance abusers have much lower costs for primary care and emergency room care. ... Effective alcohol and drug treatment also reduces the costs of other safety net programs for these clients.”⁵⁸

Have a Voice in Developing Health Care Policy Managed care is constantly evolving in response to the concerns – and advocacy – of doctors, patients, businesses and government regulators. Drug courts and the treatment providers with whom they work should try to get a seat at the table when states decide how to create or modify managed care regulations. Some states have used focus groups, surveys, public hearings and forums to obtain input from a broad range of constituents, including consumers, families and medical providers.⁵⁹ Whatever the route, drug courts and their treatment providers need to make sure decision-makers understand treatment issues, the nature of addiction and how drug courts work. They can also advocate for policies that would improve the functioning of drug courts. For instance, they can push for rules requiring managed care organizations to include in their networks a range of provider types so that drug courts can match clients with the most appropriate forms of treatment. As Susan Becker points out, “All treatment modalities need to be included in [a managed care] plan, so that a continuum of care is being provided and all levels/types of care are offered.”⁶⁰

Drug court practitioners can also advocate for the inclusion of providers based not merely on professional credentials but social needs as well. In that way, states might require managed care organizations to include in their panels organizations that have worked with specific cultural or ethnic groups, or require managed care organizations to allow enrollees to maintain previously established relationships with providers.⁶¹

Court planners might also want to argue for rules that compel managed care organizations to be more flexible when determining eligibility for type and length of treatment. While managed care organizations favor rigid criteria, drug courts are better served by a system that’s more adaptable.

Enlist the Client’s Aid When Dealing with Managed Care Organizations Sometimes a client’s cooperation is essential in order for a treatment provider to obtain payment from an insurer. In order for a check to be cut, a client may need to obtain a pre-approval or undergo a medical examination or follow-through on an appeal process. But substance abusers are notorious for missing appointments and avoiding responsibility. The court itself may therefore want to monitor a client’s compliance in this area and apply pressure in the form of sanctions. InAct, the official drug court-designated treatment provider in Portland, Oregon, generated a list of clients who failed to

do all they could to obtain coverage through their HMOs. “We gave the list to the court, and said, “These folks are impacting X amount of revenue, and we’re going to hold them out of groups if they don’t cooperate,” Valerie Moore, the director of the program, says. “And the judge began to sanction them in open court and, in about a month, lo and behold, we started to get cooperation.”⁶²

Develop Court-Based Solutions to Address Holes in Managed Care In response to some of the problems fueled by managed care, some drug courts have developed in-house responses. For instance, rather than have clients wait days or even weeks to be approved for treatment by a managed care plan, some courts have developed pre-treatment education programs to engage clients in treatment immediately. Some have also established their own health clinics to provide basic medical care to clients awaiting placement.

Conclusion

Weighed against the pressing concerns of managing difficult caseloads, managed care may, at first, seem like a remote concern to those creating or running a drug court. But the fact is that managed care now dictates how the majority of Americans receive their health care – including drug and alcohol treatment. The same is true for managed care organizations: While decisions made in a courtroom might seem of little concern to officials at health insurance companies, such firms cannot ignore the growing number of court-ordered clients seeking care.

American society clearly sees a need for both drug courts and managed care organizations. And each in their own way has enjoyed success, which virtually guarantees that the influence of both will continue to grow in the years ahead. As they grow, they will find more and more that their work and their clients intersect. It is therefore crucial that drug courts and managed care organizations develop a better understanding of each other so that they build on each other’s strengths rather than focus on each other’s perceived weaknesses.

As this paper explains, drug courts and managed care organizations approach the issues of drug abuse and treatment differently. The areas of potential conflict are many: treatment modality, length of stay, even definitions of what it means to be addicted. Some of these conflicts are rooted in historical mistrust of each other. Some are based on philosophical differences about goals of treatment, the role of social influences on drug addiction and the measures that constitute a treatment “success.” And some are based on simple misunderstanding and miscommunication. But over time, drug courts and managed care organizations can move beyond these obstacles. To do so, they must open lines of communication, understand each other’s needs and find common ground.

One point of commonality is their shared desire to change people’s lives and improve the health of their clients. Perhaps building on this core foundation, drug courts and managed care organizations can establish effective partnerships that allow them to pursue their separate missions in an environment of mutual respect and cooperation.

Endnotes

1. Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project, “Summary of Drug Court Activity by State and County, Nov. 7, 2003.” There are 1,093 drug courts in operation and 414 more being planned.

2. At its annual meeting in August 2001, American Bar Association delegates adopted a resolution endorsing the principles and methods of “problem-solving courts.” The resolution specifically referred to drug courts, as well as community courts, mental health courts and domestic violence courts. The Bar Association resolution called for “the continued development of problem-solving courts to improve court processes and court outcomes for litigants, victims and communities.” The Conference of Chief Justices and the Conference of State Court Administrators jointly adopted a similar resolution on Aug. 3, 2000.

3. “Managed Care Fact Sheets: Managed Care National Statistics,” 2003, Managed Care On-Line, 19 Feb. 2004 <<http://www.mcareol.com/factshts/factnati.htm>>.

4. Statistics showing how many drug court clients nationally have Medicaid are not available. Anecdotally, however, it appears, in urban settings at least, that the majority of drug court participants are Medicaid eligible.

5. “Enrollment and Plan Participation Trends in Medicaid Managed Care,” American Association of Health Plans, July 2001.

6. “Savings Due to Managed Care,” *Managed Care Facts*, the American Association of Health Plans, October 1999. In 1997, health care spending in the U.S. rose only 4.8 percent, the smallest increase in almost 40 years.

7. Steven Belenko, “Research on Drug Courts: A Critical Review Update,” The National Center on Addiction and Substance Abuse at Columbia University, June 2001.

8. Leslie Scallet, Cindy Brach, Elizabeth Steel, eds. 1997. *Managed Care: Challenges for Children and Family Services*. Introduction. Baltimore, MD: The Annie E. Casey Foundation.

9. Daniel Forget, phone interview, July 12, 2001.

10. Says Anita Marton, a senior attorney at the Legal Action Center, a public interest law firm that has studied the relationship between managed care organizations and the courts: “Providers depend on contracts with managed care companies, and managed care companies keep a careful watch on which providers advocate most for their clients. The plans don’t want them... Because of this, providers sometimes bend to the pressures of the managed care companies.” Anita Marton, phone interview, July 2001. Also, Brach and Scallet have pointed out that “the roles of provider and insurer [have] become increasingly integrated.” This means that “clients cannot count on providers to be their advocates. Even when providers are not at financial risk, they may worry about jeopardizing their relationships with managed care organizations if they repeatedly appeal denials.” See Cindy Brach, Leslie Scallet, *Cross-Cutting Issues, Managed Care: Challenges for Children and Family Services*, eds. Leslie Scallet, Cindy Brach, Elizabeth Steel, Baltimore, MD: The Annie E. Casey Foundation, 1997.

11. “A Brief History of Managed Care,” Tufts Managed Care Institute, 20 Dec. 2001 <<http://www.tmci.org>>.

12. The term “health maintenance organization” was coined by Dr. Paul Ellwood, a physician advising the Nixon administration. See Timothy Kelley, “An Interview with Paul Ellwood Jr., M.D,” *Managed Care*, Nov. 1997.

13. “A Brief History of Managed Care,” supra note 11.

14. Uwe Reinhardt, “The Managed-Care Industry in Perspective,” WGBH/Frontline, 1998.

15. Health maintenance organizations dispense medical care through: their own staff (a staff model HMO); groups of physicians who provide care exclusively for the managed care organization’s members (a group-practice HMO); a variety of physician groups as well as hospitals and other health care providers (a network HMO); or through physicians who remain in their independent office settings, where they can see both members of managed care organizations as well as private-pay patients (an individual practice association HMO).

16. Some PPOs also let patients visit non-participating providers, but to do so, the patient has to pay more out of his or her own pocket.

17. “Virtually every health plan, even those considered to be fee-for-service, use some form of managed care like requiring pre-authorization for certain services,” says Louis Saccoccio, general counsel of the American Association of Health Plans, a national trade group. Saccoccio, phone interview, Sept. 4, 2001.

18. In one example of how Medicaid programs were not immune to sky-rocketing health care costs, mental health and alcohol or drug treatment costs grew in Massachusetts in the late 1980s at a rate of over 20 percent a year – the fastest growing component of that state’s Medicaid system. See Stephen B. Moss, “The Massachusetts Experience: Managed Behavioral Care in the Public Sector,” in *Treatment Improvement Exchange Communique*, Center for Substance Abuse Treatment, Spring 1995. See also John Holahan, Suresh Rangarajan and Matthew Schirmer, “Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey,” Urban Institute, June 1999.

19. John Holahan et al.

20. “Enrollment and Plan Participation Trends in Medicaid Managed Care,” supra note 5.

21. Brian Bruen and John Holahan, “Slow Growth in Medicaid Spending Continues in 1997,” Kaiser Commission on Medicaid and the Uninsured, November 1999.

22. Bruen and Holahan.

23. David Liska, “Medicaid: Ten Basic Questions Answered,” Urban Institute, Nov. 1997.

24. Mady Chalk, “Privatizing Public Mental Health and Substance Abuse Services: Issues, Opportunities and Challenges,” *Quality Management in Health Care*, 1997.

25. Madeline A. Estabrook, “Attacks Prompt Examination of Mental Health Care Funding,” *Managed Care*, Nov. 2001.

26. The Hay Group, “Substance Abuse Benefit Cost Trends 1988-1998,” unpublished report commissioned by The American Society On Addiction Medicine, 1998.

27. Working Group of the American Society of Addiction Medicine Managed Care Initiative, “The Impact of Managed Care on Addiction Treatment: A Problem in Need of a Solution,” April 28, 1999.

28. David Gates, Client Protections in Managed Care, *Treatment Improvement Exchange Communique*, Center for Substance Abuse Treatment, Spring 1995.

29. Melissa Wyman Paquin, Dawn Lambert-Wacey, Patricia Perry and Robert Gallati. “Quantitative and Qualitative Analyses of Trends in Access to and Utilization of Alcohol and Substance Abuse Treatment in New York State.” Nov. 1999. Poster presented at the annual meeting of the Association of Health Services Research, Los Angeles, California. Since a substantial number of services remain outside New York’s Medicaid managed care benefit package, enrollment in Medicaid managed care was not associated with differences in outcome, the researchers found. Patricia Perry, phone interview, Jan. 3, 2002.

30. Paquin et al.

31. Forget, *supra* note 9.

32. Dennis D. Deck, Bentson H. McFarland, Jessica M. Titus, Katherine E. Laws and Roy M. Gabriel, “Access to Substance Abuse Treatment Services Under the Oregon Health Plan,” *Journal of the American Medical Association*, Vol 284, No. 16. Oct. 25, 2000.

33. Susan Galbraith of the Legal Action Center in Washington D.C., points out that because of managed care “many consumers now have reduced access to treatment services, programs have closed and many states have either reorganized their alcohol and drug treatment systems or have plans underway to do so.” (Susan Galbraith, “Preserving the Integrity of Alcohol and Other Drug Treatment in a Managed Care System: Is It Possible?” *Treatment Improvement Exchange Communique*, Center for Substance Abuse Treatment, Spring 1995.) Cindy Brach and Leslie Scallet further point out that “the provider community ... needs time to adjust [to implementation of managed care.] Managed care organizations may have little experience in dealing with the needs of multi-problem individuals. They need adequate time for planning, obtaining client input, and developing quality assurance systems... In the case of traditional providers, long-established approaches to delivering services must change... Unless given time to learn, the provider community is likely to become unstable, creating vacuums in the service delivery system.” Brach and Scallet, *supra* note 10.

34. Chalk, *supra* note 24.

35. “Health Care Quality: Outcomes and Satisfaction,” *Managed Care Facts*, American Association of Health Plans, Oct. 1999.

36. Laureen Oskochil, former chemical dependency managed care coordinator for CareOregon, a Medicaid managed-care provider, phone interview, August 21, 2001.

37. Judge Richard S. Gebelein, phone interview, July 2001.

38. In addition, a “stop-loss” provision in New York also pays for services that exceed Medicaid managed care limits. This means that, for example, if a client needs more than 30 days of inpatient alcohol or substance-abuse treatment – the maximum

allowed under Medicaid managed care – the extra care is paid for by the state under the stop-loss provision. In essence, the managed care organization is still responsible for paying the provider and managing the client’s care; but they are entitled to extra reimbursement from the state for any care that exceeds the stop-loss limits.

39. A report published by the federal Center for Substance Abuse Treatment recommends that vocational services be made an integral component of all substance abuse treatment programs. “Substance abuse treatment that is cost-effective and shows verifiable positive outcomes is the ultimate goal. However, this goal cannot be achieved unless all the client’s service needs are met, and this will occur only through the integration of treatment and wraparound services, including vocational counseling and employment services.” The report points out, among other things, that “employment has been positively correlated with retention in treatment.” Further, the report notes that “employment ... helps moderate the occurrence and severity of relapse to addiction.” See “Integrating Substance Abuse Treatment and Vocational Services,” *Treatment Improvement Protocol Series 38*, Center for Substance Abuse Treatment, Rockville, Maryland, 2000.

40. Historically, health insurance plans of all types – managed care or fee-for-service – have not covered wraparound services.

41. Treatment providers have, in the past, shared this attitude: “The standard approach has been to take care of clients’ addiction problems, and in doing so issues such as employment would take care of themselves because of clients’ increased self-esteem and desire to succeed.” See “Integrating Substance Abuse Treatment and Vocational Services,” *supra* note 39.

42. In some extreme cases, HMOs have been known to deny court-ordered treatment as a matter of policy. “The managed care organization will say this person doesn’t need treatment. All they did was break the law, and we don’t pay for mandated treatment,” says Valerie Moore, executive director of InAct, a treatment provider in Portland, Oregon. In such situations, treatment providers have to make an extra effort to document the client’s drug use. “We’ll start treatment and then show them testing results and say, ‘See, they do use drugs,’ ” Moore explains. “Then they usually OK treatment but generally for something like three days of treatment, which is far less than the client needs.” Valerie Moore, phone interview, July 17, 2001.

43. CareOregon, for instance, will pay for weekly drug testing only through the first 90 days of sobriety. “After 90 days of abstinence, what is the clinical reason to do it once a week?” asks Laureen Oskochil, the former chemical dependency managed care coordinator for CareOregon, a Medicaid managed-care provider. “The drug court may still want the client to be tested as part of the monitoring, but what’s the medical need? There isn’t one.” Oskochil, *supra* note 36.

44. “In the past, health insurers saw courts sending clients to treatment to punish them without any clinical evaluation to back it up. That contributed to a sense of distrust between the insurance companies and the courts,” says Valerie Raine, director of drug treatment programs at the Center for Court Innovation. Valerie Raine, in-person interview, Jan. 2, 2002.

45. Holmes notes that the contract itself won't eliminate all conflicts. "We have to build understanding on both sides. The judges need to understand that in order for these things to be paid for, there are some criteria. And the managed care organizations need to have some flexibility, and sometimes provide the court-ordered service even if they may not have done it exactly that way on their own," Holmes says. Kay Holmes, phone interview, Aug. 22, 2001.

46. Chalk, *supra* note 24.

47. Judge Robert Russell, phone interview, July 19, 2001.

48. A recent study of drug courts in New York State found an average 29 percent recidivism reduction over a three-year post-arrest period when compared with similar defendants who did not enter drug court. Michael Rempel, Dana Fox-Kralstein, Amanda Cissner, Robyn Cohen, Melissa Labriola, Donald Farole, Ann Bader and Michael Magnani, "New York State Drug Court Evaluation: Policies, Participants and Impacts," Center for Court Innovation, Oct. 2003.

49. Jack O'Connor, phone interview, June 20, 2001.

50. Greg Nuessle, phone interview, Sept. 2001.

51. "Behavioral Health System at a Glance: Community Behavioral Health," 2 Jan. 2002 <<http://www.phila-bhs.org/cbh.html>>.

52. Huntly Collins, "Mental-Health Care Changes Set for Medicaid Patients: P.A. Will Contract with Counties, Not Companies," *The Philadelphia Inquirer*, Sept. 20, 1996.

53. Craig R. McCoy and Dianna Marder, "The Fight on Mental-Health Care for Indigent: How Ridge and Rendell Tried to Overhaul the System to Wrest Control from HMOs," *The Philadelphia Inquirer*, Jan. 7, 1997.

54. Barry Savitz, phone interview, July 2001.

55. "Philadelphia Behavioral Health System Wins Innovations in American Government Award," press release, The Innovations in American Government Program, Oct. 14, 1999.

56. Amy Hafner, phone interview, Jan. 3, 2002.

57. Forget, *supra* note 9.

58. Susan L. Becker, Managed Care: Meeting the Challenge to Substance Abuse Treatment, *Treatment Improvement Exchange Communique*, Center for Substance Abuse Treatment, Spring 1995.

59. Susanna Ginsburg and Sharon Carothers, Designing Managed Care Alternatives, *Managed Care: Challenges for Children and Family Services*, eds. Leslie Scallet, Cindy Brach, Elizabeth Steel, Appendix B, Baltimore, MD, The Annie E. Casey Foundation, 1997.

60. Becker, *supra* note 58.

61. Ginsburg and Carothers, *supra* note 59.

62. Moore, *supra* note 42.

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